Frank Porporino
Research Division

Robin A. McGee
Research Assistant

Robert Joseph
Research Assistant

COUNTERMEASURES TO PRISON VIOLENCE: A SURVEY OF CORRECTIONAL JURISDICTIONS

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INTRODUCTION

In recent years, there has been a growing interest in the phenomenon of prison violence. Concern is warranted: studies revealing the escalation of violence in prisons indicate the existence of a serious social problem (Gibb, 1981; Cohen, Cole and Bailey, 1976; Porporino and Marton, 1983). Incidents of all kinds have shown substantial long term increases. The number of inmates incarcerated for violent crimes has also increased. The accumulation of violent men in threatening and disruptive prison environments excacerbates the situation. For these reasons, the handling and management of the violent offender is an issue of critical importance to the Canadian correctional system.

Traditionally, attempts to reduce prison violence have relied on heightened levels of control and surveillance. Punitive and administrative segregation are common. Equally prevalent is the use of emergency transfers to psychiatric facilities to deal with the violent inmate. These strategies have been criticized, both for their limited success and their failure to address the complexity of the phenomenon (Porporino and Marton, 1983; Toch, 1982). Prison violence has a multiplicity of causes. It is a complex function of both the incarcerated individual and the specific circumstances of his environment. These sweeping, simplistic measures cannot reduce

violence in the long term. To be effective, countermeasures must acknowledge the diversity of elements operating in the display of aggressive behaviours; alternative and supplementary countermeasures need to be developed by correctional institutions.

The field of exploration is young, however. Few progressive programs are in place in correctional institutions, and the relevant research is scant. In order to review and assess current treatment strategies for violent offenders, the Research Division of the Solicitor General instituted a survey of the practices of jurisdictions around the world. This report presents a summary of the findings, as well as a review of the relevant literature. The primary aim is to provide a description of strategies that could be feasibly applied to the Canadian prison context.

METHODOLOGY

In the summer of 1983, the Research Division conducted an investigative survey of correctional jurisdictions, inquiring into their strategies for the handling and management of violent offenders. One hundred and forty five letters were mailed. The survey sample included the correctional departments of the Canadian provinces and territories, the Federal Bureau of

Prisons and all state jurisdictions in the United States, the British Home Office, and other jurisdictions in Europe and Australia. The letter of inquiry (see Appendix A) specifically requested information on countermeasures other than traditional security measures "that have shown promise in the treatment of certain types of violent prisoners". It also asked for copies of relevant reports, published or unpublished. Finally, respondents aware of any treatment programs implemented in other jurisdictions were asked to inform us.

Sixty-one replies were received; a response rate of 45%. (Appendix B contains a list of respondents and non-respondents). Of those, 11 were general comments by criminology researchers. Fifty replies were from the jurisdictions themselves. Eighteen of those stated that they had no treatment programs for violent inmates beyond punitive measures. Thus, there were 32 responses that supplied information on current interventions. Appendix C indicates which jurisdictions reported using specific countermeasures.

The letters of reply were generally brief, single-page statements devoid of detail. Only five jurisdictions provided comprehensive descriptions of their institutions and programs, and only four forwarded any evaluative studies or reports. Three mentioned that studies assessing the efficacy of their current

treatments were underway. Three more said that intervention strategies were presently in the planning stages.

All the information was compared, similarities and differences noted, and the treatments organized according to their general characteristics. The first section of this report discusses the incidence of traditional approaches to the violent offender. Punitive and administrative segregation are discussed and critically evaluated. The classification of the violent offender as mentally ill, and consequent psychiatric treatment, is also critically examined. The prevalence of both these strategies in the survey sample is reported.

An analysis of the replies we received suggested that non-traditional treatment approaches to the violent offender can be dichotomized into two major categories: those aimed at changing the individual inmate, and those designed to modify the social-psychological environment in which he lives. The first orientation focuses specifically on the inmate's aggressive behaviour and attitudes, utilizing such techniques as contingency management, social and cognitive skills training, and individual and group therapies. These interventions are discussed in the second section of this report. As a general pattern, each technique will be described, its incidence in the sample of jurisdictions will be reported, and the relevant evaluative literature will be cited.

The third section of this report describes those approaches which address aspects of the prison environment, particularly staff/inmate communication. Sometimes these models entail architectural changes, such as tier systems and therapeutic communities. Others, such as privilege stratification, contracting and inmate staffing are applied globally throughout the institution. Each approach attempts in some way to alter the structure of the prison's social organization. Subcultural norms that encourage violence - such as the ascription of status to the violent - are ideally supplanted by prosocial alternatives.

Correctional staff are a vital component of the prison social organization. Given the primacy of social dynamics in the evolution of violence, their role as mediators and interveners in times of crisis and conflict becomes critical. They must be carefully selected and trained to maximize their effectiveness in staff/inmate interaction. The fourth section of this report describes the staffing of treatment programs. The selection criteria and the preparative training found in the jursidictions is reported and reviewed.

The final section of this report deals with the general rehabilitative programs described by some respondents. Although

not specifically aimed at the reduction of individual aggressiveness or social hostility, these may have general emendatory value in these areas. The provision of meaningful activities serves to divert the restless inmate and keep him sufficiently occupied. Contact with others in these contexts may encourage group solidarity and morale. Educational courses, vocational training, religious services and recreation programs offered by the jurisdictions are reviewed, and some evaluative literature presented.

A note of explanation is necessary: the programs described are not mutually exclusive. They can be (and often are) applied concurrently. The ideal programming approach employs a broad range of therapeutic techniques and organizational interventions. Special attention must be given to matching the appropriate inmate to the appropriate program. Violent offenders differ significantly in the reasons for their actions - these reasons must be effectivly addressed for significant change to occur.

I. TRADITIONAL APPROACHES

A. Punitive and Administrative Segregation

The predominant practices currently used to manage the violent offender are the disciplinary measures of confinement and segregation. Several reasons are proposed for their use: incapacitation and protection of others over the short term, and deterrence for the inmate population in the long term. Punitive confinement and other security measures were the most common approaches to prison violence found in our sample: thirty-seven (74%) of the 50 responding jurisdictions utilized these methods. For 20 (40%), they were the only methods used.

The adequacy of coercive measures in the reduction of prison violence is a polemical issue in corrections. Their proported long-term effect has simply not bourne the test of empiricism. Even extreme security clampdowns do not result in significant reductions in certain kinds of violence (Quinsey and Varney, 1978; Binda, 1975) and may even exacerbate it (Porporino and Marton, 1983). There is some evidence that a small percentage of inmates are consistently involved in violent incidents (Bennet, 1976). Punitive segregation seems to have a weak deterrent value. Why?

A number of explanations have been posited. First, a great deal of minor violence goes undetected (Ellis, Grasmick and Gilman, 1974). The inmate subculture seriously militates against the reporting of inter-inmate aggression by prisoners. As many as 25% of inmate assaults have no official witnesses (Porporino and Campbell, 1983). Inmates learn they can escape detection and consequently avoid punishment. Second, there are many intangible gains accruing to violent behaviour which outweigh the costs of disciplinary action. The excitement of "fighting the system", the gratification of revenge and the elevation in subcultural status and notoriety brought about by violence are prized by many inmates. This is true also of the material gains (eg. money, drugs, sex) for which some inmates would fight or kill. Third, inmates can become habituated to punitive confinement, and some may even find it a rewarding experience (Suedfeld and Roy, 1975; Sueldfeld, Ramirez, Deaton, and Baker-Brown, 1982). It can be time out from the pressures and impositions of general prison routine, as well as an opportunity for privacy and contemplation. Finally, coercive measures do nothing to confront the problems of those prisoners whose violence stems from mental or behavioural disorders. Disciplinary measures are obviously not enough. To be effective, punitive and administrative segregation must be complimented by other strategies to counteract prison violence.

B. Psychiatric treatment

This approach refers to the provision of treatment for those violent inmates diagnosed as mentally ill. Certain disturbances seem to predominate: typical diagnoses for which psychiatric institutionalization are needed include schizophrenia, acute depression and mania, and pronounced mental deficiency. The practice of psychiatric treatment as a means of dealing with violent prisoners is common; ten (20%) jurisdictions utilized it. There were essentially three variants of this approach reported by the respondents. Two (4%) provided psychiatric counselling within the general institution. In six jurisdictions (12%), acutely disturbed inmates were segregated into special mental health units. Transfer to a state psychiatric hospital was reported by three (6%) jurisdictions, two of which made this their only method of dealing with violent inmates.

The specific treatments given ill offenders vary with their particular disorder and the institutional setting in which they are placed. However, three elements are common to most psychiatric approaches to the violent patient: restraint, interviews, and the use of psychotropic drugs. Research into the latter has burgeoned in recent years. Anticonvulsants ,such as those used with epileptics, has been effective with cases of

organic brain dysfunction (Munroe, 1978). Anti-anxiety agents appear to actually increase violent behaviour in aggressive inmates (Workman and Cunningham, 1975). The most promising drug research in this area has been with lithium. A number of well-designed studies have confirmed its efficacy in reducing aggressive affect, behaviour and tension in violent prisoners (Sherard, 1971; Tupin, 1973; Sherard, 1973; Sherard, Marini, Bridges and Wagner, 1976; Sherard and Marini, 1978). It appears to work best with inmates who have no overt brain damage or psychosis, and who view their aggressive impulses as undesirable (Sherard, 1973). However, there are problems associated with its use. Refusal, side effects and the reappearance of aggression after the drug is discontinued limit its applicability. Complimentary interventions are still necessary.

Considerable criticism has been leveled at the exclusive use of psychiatric treatment for violent offenders. Perhaps the most serious charge is that it is too global: not all violent men are mentally ill, or disordered enough to warrant psychiatric institutionalization. The distinction between psychopathology (mental disorders with gross distortions of reality) and sociopathology (marked antisocial behavior stemming from defective socialization) is obscured and ignored. Each requires specialized treatment; the techniques used for one are

not amenable to the other (Greenland, 1978; Sturup, 1976; Conrad and Dinitz, 1977). An overpropensity to use psychiatric labels is excessivlely polarizing, and leads to misdiagnosis, inefficient allocation of services, and futile treatment efforts (Toch, 1980a). One particularly counterproductive strategy is the "bus therapy" described by Toch (1982). The disturbed, disruptive inmate is shuttled off to the mental institution because of the prison's inability to deal with his illness; the mental hospital sends him back because they can not manage his violence. The consequence is a fatuous merry-go-round from which nobody benefits. In summary, the dichotomization of violent inmates as either "bad" or "mad" ignores the existence of a continuum of social or mental deviance. Treatments should reflect this complexity, and be suited to the degree of disturbance.

Problems of policy and legal interpretation also have their genesis in the tendency to equate violence with insanity (Greenland, 1978; Rappeport, 1978). To what extent does illness excuse responsibility? How should it effect sentencing? What are society's responsibilities vis a vis this kind of criminal? Where should he be incarcerated, and what should be done with him? Can atrocious crimes be committed "in sound mind"? Answers to these questions are obfuscated by the global attribution of violent behaviour to personal pathology.

Another criticism of the psychiatric approach is that its emphasis on an internal locus of aggression ignores the social and environmental precursors and determinants of violence (Toch, 1978; Suedfeld, 1980; Ellis et al., 1974). Evidence indicates that violence, particularly prison violence, arises from a subculture that emphasizes physical dominance and toughness as a means to social status. When coupled with the deficits in self-esteem and social perception common in violent men (Toch, 1969), this milieu breeds aggression. Toch (1969) describes the violent inmate as "domineering, blustering, self-advertising and afraid" (p. 222). These individuals are prone to interpreting innocuous situations as provocative or threatening. The complex interaction between the social order and the individual is not tapped into by a strict psychiatric approach.

One further criticism concerns the lack of supplementary treatment in a "medical model of violence" (Rappeport, 1978). Once the ill offender is "cured", he is left to his own resources; often without follow-up treatment to help him deal with the stresses that precipitated his violence or psychosis. Even if the psychiatric approach was correct in its assumption that all violent men are necessairily mentally ill, there is still a vital need for behavioural and attitudinal retraining once the symptoms of mental illness have been controlled. Moreover, the implicit notion of the medical model - that

experts cure a passive patient does not encourage the inmate to take responsibility for his own progress. Perceptions of having no control over oneself or one's fate may actually exacerbate psychological deterioration in some offenders.

Both valid and necessary in their own right, punitive and psychiatric approaches are nevertheless insufficient to deal with prison violence. The following sections present and discuss the many alternatives that other jurisdictions and empirical researchers have explored.

II. CHANGING THE VIOLENT OFFENDER

The following treatment strategies have a common focus: the individual offender is considered the unit of change. Some go about this by attempting to directly influence specific behaviors, others by altering the inmate's internal perceptions and attitudes. All, however, are predicated on an understanding of aggression and the functions that it serves.

A Model of Aggression

Although there are a number of theories about aggression, the most comprehensive and sophisticated is that proposed by Zillman (1978). It is a conceptually cohesive amalgamation of previous models (for review see Fehrenbach and Thelen, 1982). According to this model, there are three factors that influence the expression of hostile and aggressive behaviour:

1. The reward value of violence. If the individual has been reinforced often enough for violent behaviour, the probability of its occurrence increases. It can be instrumental in two ways: in attaining rewards and incentives (e.g. status, money, retribution) or in providing an efficient means to alleviate annoyance(e.g. frustration, provocation). These two forms are called incentive-motivated aggression and annoyance-motivated aggression, respectively.

2. The involvement of cognitive processes. Some cognitions facilitate anger, others mitigate it. Perceptions concerning the violation of norms, anticipation of the consequences and dangers of aggressive action fall into the latter category. Causal attributions (and misattributiions) of malicious or provoking intent by others are often the cognitive antecedents of violence.

3. The individual's state of physiological excitation. According to Zillman (1978), arousal determines the extent to which cognitive guidance will predominate over simple learned aggressive responses. Incentive - motivated aggression is associated with intermediate levels of excitation; actions are clearly planned and controlled. Annoyance - motivated aggression may occur at any level. However, cognitive control is severely compromised when the individual reaches a high state of physiological arousal. This is "blind rage": the aggressor looses sight of possible consequences, feeling only that his attack is justified. Violent actions (such as destructive behaviours) may be used to escape this escalation of acute tension.

Zillman's (1978) theory asserts that the individual's reinforcement history for aggression is a fundamental determinant of violent action. The behaviours and cognitions

involved in its display are socially learned; that is, they have been picked up through observation. Because this is true also of prosocial behaviours, the suggestion is that violent individuals can learn more appropriate means of action if taught by the right methods. These concepts have important implications for treatment programs which are the subject of the rest of this section.

A. Contingency Management

This treatment regimen is aimed at altering the reinforcement patterns surrounding the violent individual. Contingency management is defined as "the contingent presentation and withdrawal of rewards and punishments" (Rimm and Masters, 1974, p.166). It is predicated on four essential procedures:

a. Positive reinforcement, in which a reward is granted for the the overt demonstration of the desired behaviour;
b. Negative reinforcement, the termination of an aversive situation upon the display of prosocial behaviour;
c. Punishment, the presentation of an aversive stimulus or situation for undesirable actions; and
d. Removal of Positive Reinforcement, which is the suspension or withdrawal of rewards for inappropriate behaviour displays.

The last three techniques are maximally effective if subsequent or continued prosocial behaviour is differentially reinforced. (Fehrenbach and Thelen, 1982).

Of crucial importance to the efficacy of any contingency management program is the immediate and consistent application of rewards and punishments. To realize both, training in the relevant techniques is essential for those in daily contact with the prisoner(s). Adequate staff preparation is critical: one of the jurisdictions that had attempted contingency managemnent were forced to abort it due to "staff resistance". An enormous number of studies demonstate the success of contingency management in the reduction of aggressive behaviour (for reviews see Carr,1981; Fehrenbach and Thelen, 1982). It appears to be the most appropriate treatment strategy for cases of mental deficiency, brain damage and/or psychosis (Foxx and Azrin, 1972; Hamilton, Stephens and Allen, 1967; Carr, Newson and Binkoff, 1976: cited in Carr, 1981).

Most contingency management programs are directed at a single individual. However, modifications have been developed to allow global application in institutional settings. In prisons, these are token economies and Time Out treatments.

1. Token Economy

This is a system in which inmates are given or fined "tokens" (a kind of internal prison currency) on the basis of their overt behaviour. Tokens can be exchanged for valued commodities such as cigarettes or access to recreational facilities. Ideally, this system encourages prisoners to assess the response cost of hostile and aggressive action by defining reward and punishment in concrete terms. Although the token economy was not found in the survey sample, it has been subject to extensive empirical evaluation. With respect to the reduction of aggressive behaviour, its usefulness has been demonstrated with institutionalized juvenile delinquents (Phillips, 1968; Burchard and Barrera, 1972) adult psychiatric patients (Kazdin, 1977) and prison inmates (Ayllon and Azrin, 1968).

2. Time Out

Particularly effective with young, retarded or schizophrenic aggressives, Time Out entails the removal of all sources of reinforcement for a specified period of time upon the incidence of undesirable behaviour. The offender is removed from his situation and sent alone to a "time out room" devoid of any stimulation or potential reinforcement. Although the ideal

duration of isolation depends on the individual and infraction involved, time out should not be more than two hours or less than ten minutes (Benjamin, Mazzarins and Kupfersmid, 1983).

Time Out was used to deal with violent outbursts by one of the jurisdictions in our sample (West Australia). Although this jurisdiction did not comment on its effectivness, Time Out's utility as a management tool has been confirmed in the literature. Significant reductions in assaultive behaviour have been demonstrated with aggressive juveniles (Robinson,1979; Bowstow and Bailey, 1969) as well as adult retardates and psychiatric patients (Edwards,1974; Benjamin, Massarins, and Kupfersmid, 1983).

In summary, contingency management techniques have relevance for annoyance-motivated aggression as well as minor incentive-motivated actions. With one exception, it was not used by any of the reporting jurisdictions. Although there are few studies evaluating it with aggressive adult inmates per se, its empirically demonstrated success makes it a promising alternative. It is ideally suited to inmates who can benefit from such a concrete technique, particularly those with borderline to severe deficits in mental ability.

B. Social Learning Approaches

The following treatments, which all can be described as social learning models, share a number of common assumptions about the genesis of aggression. The instrumentality of violence for some individuals stems from skill deficits in socially appropriate ways of achieving goals and dealing with annoyance. Aggression is directly and inversely related to social competence. Unlike the contingency management approach, this model asserts that prosocial behaviours are not in the aggressive inmate's repetoire: he must be taught them. Once acquired, they will supplant aggressive responses because of their superior utility in social situations. A consequent elevation in self-esteem arising from social and self mastery will help ameliorate the sense of inadequacy in which violence has its source (Toch, 1969).

Social learning treatments can have two foci: embellishment of the client's overt behavioural repertoire, or the shaping of appropriate perceptual and self-regulatory cognitions. Some, such as Anger Management, offer both. Usually, cognitive-oriented strategies are given concurrently with relaxation training. The latter helps to diminish the physiological arousal associated with aggressive behaviour.

Each of the treatments employ a similar sequence of teaching techniques. The prototypical process, which has garnered considerable empirical support, is Structured Learning Therapy (SLT). The latter employs four elements:

a. Modelling, where the trainee is exposed to numerous specific and detailed examples (sometimes through film or videotape) of a person performing the desired behaviour;

b. Rehearsal, where the trainee reenacts the observed behaviour or role plays it in a hypothetical scenario;

c. Performance Feedback, where the therapist responds to the client's rehearsal through constructive criticism, positive reinforcement and repetition of the previous steps; and

d. Transfer Training, where the client practices the skill in real-life situations, with his actual social partners, under varying conditions and degrees of social reinforcement.

These procedures are often, but not necessarily, sequential in their arrangement. The following five social learning treatments are found in both the survey sample and corrections research.

1. Social Skills Training (SST)

This treatment is used primarily to teach overt behaviour, as opposed to restructuring cognitions or other internal states.

A formal definition is provided by Goldstein (1981):

> Social Skills Training is the planned systematic teaching of the specific behaviours needed and consciously desired by the individual in order to function in an effective and satisfying manner, over an extended period of time, in a broad array (of) positive, negative, and neutral interpersonal contexts. (p. 162)

The skills themselves are concretely and narrowly defined. Each are subdivided into incremental steps, which are imparted in sequence. A number of skills taught by this method (listed in Goldstein, 1981) have been identified for their relevance to aggression. General areas are communication skills, planning and decision-making skills, and "life skills" such as home or money management.

Of the 50 responding jurisdictions in the sample, social skills training was used by four (8%). Interpersonal/Communicatiions skills were taught at three (6%). Training in skills of daily living was offered at two institutions, both in the jurisdiction of Washington. Two jurisdictions focused on job acquistion and workplace-related skills (e.g. going for an interview, dealing with a strict boss). None of these respondents forwarded any evaluative data.

The research literature, however, has been generally favourable to SST, provided the right candidates are selected.

As indicated in Goldstein's definition, the client must be motivated to learn and change. A normal IQ and relatively unimpaired perceptual ability should be participation criteria. Hostile and aggressive behaviour has been reduced in assaultive juveniles (Wood,1978; Hummel, 1980; Goldstein, 1978; Raleigh, 1978; Pentz, 1980; Warrenfeltz, 1981) and disruptive psychiatric patients (Elder, Edelstein and Narick, 1979) through the use of SST.

2. Relaxation Training

This treatment, although not strictly a social learning approach, is often used in conjunction with cognitive restructuring methods. It is defined as "the systematic application of tension-sensitizing and tension release procedures in order to achieve a state of deep muscular relaxation" (Carr and Binkoff, 1981, p.111). The client is helped to recognize those physiological cues which indicate the onset of anger. There are four variants of RT which have applicability to the treatment of aggression.

a. Differential relaxation (Jacobson, 1938). This technique enables a skilled client to relax select muscle groups, while others remain active. This is particularly useful, in that it allows relaxation training to carry over into daily activity.

b. Cue controlled relaxation (Paul, 1966). The client learns to pair relaxation with some cue word such as "easy now" or "calm down". When in an anger-provoking situation, repetition of the cue word will induce relaxing sensations and dissipate the motivating tension.

c. Systematic Desensitization. The client constructs a hierarchy of scenarios, subjectively arranged in order of their anger-producing potential. During the treatment session, the client is instructed to vividly imagine these scenarios, while concommitantly practicing relaxation techniques. Once the scene can be envisaged without agitation, the client progresses to the next item on the hierarchy.

d. Transcendental Meditation. Although not a progressive training of the kind described above, the TM technique also induces a deep state of physiological relaxation, and has proven useful in the reduction of stress and anxiety. A cross sectional and longitudinal study conducted on maximum security inmates indicated highly significant increases in ego development, as well as decreases in aggression and recidivism in TM practitioners (Alexander, 1982).

Five of the 50 responding jurisdictions (10%) reported using relaxation training as part of their treatment strategy for violent offenders. One, the Cascade Program for juveniles in Washington, employed a kind of systmatic desensitization aimed at "deconditioning the emotional imagery related to violence".

One other jurisdiction utilized it on both a group and individual basis. Relaxation training has proven effective in anger control situations, both alone and in combination with other methods (Evans, 1970; Evans, Hearn and Saklofske, 1973; O'Donnell and Worell, 1973; Rimm, DeGroot, Boord, Heimen and Dillow, 1971).

3. Rational Emotive Therapy (RET)

RET is predicated on the notion that serious, nonpsychotic psychological disturbances, such as those involving intense anger, anxiety and depression, stem from faulty or irrational patterns of thought. A distorted belief system results in grossly inaccurate perceptions of self and situations, generates inappropriate emotions, and hence violent and maladaptive behavior. RET (and its variant RBT, or Rational Behavior Therapy) activly challenge and dispute the client's self-destructive attitudes (e.g. "I absolutly must win this

argument; otherwise I am a gutless, worthless nobody"). First, the therapist vigorously points out the illogic of such beliefs, and their detremental consequences. Once the client is convinced, the pair work together to shape more clear and rational perceptions through modeling and rehearsal. Therapy may also include an educative component to aid in cognitive restructuring (e.g. teaching the distinction between thoughts and feelings). Eventually, the client will become self-monitoring, acting as his own censor of irrational thoughts.

Various irrational beliefs have been suggested as precusors of violence. Belief in the attainability of personal perfection, the impossibility of controlling one's destiny and the catostrophic consequences of unfortunate events, as well as exaggerated blame of self and others, have all been associated with aggression and hostility (Ellis, 1974). Toch (1969) has indentified others which are particularly salient in the prison subculture; that criticism from others is tantamount to personal attack, that manhood can only be demonstrated through physical prowess and intimidation, that victims "ask for" or even enjoy violence. Inmates selected for RET should display such beliefs, but not to an unalterable degree.

RET was used by two (4%) of the responding jurisdictions. At the maximum security Oklahoma State Penitentiary, all inmates must participate in Rational Behaviour Therapy. Although a thorough evaluation of the program was in process at the time of the survey, a preliminary study (see Appendix D) provides encouraging results. The report also suggests that the best candidate for this kind of therapy is of average or better intellectual functioning, is experiencing some problems related to severe distress (anxiety, depression, etc.) and is expecting to learn underlying concepts in order to use them with his specific problems. One other empirical study supports the use of RET in the management of aggression in prisons (Meers, 1979)

4. Assertiveness Training

This treatment approach is in essence a kind of communications training: its specific emphasis is on expressing one's rights and feelings honestly and directly, while still taking into consideration the rights of others. Aggressive individuals can be undercontrolled or overcontrolled (Toch, 1969; Tennet, 1975). The latter poses a special problem. He is the inmate who silently adds up his grudges, ruminates on affronts to his dignity and then plots later retribution or explodes in an aggressive outburst in an attempt to ameliorate the perceived injustices of the past. He may also displace his

anger from the inaccessible or more powerful original object onto a weaker, available target. Assertiveness Training seeks to reverse this pattern by teaching the client how to verbalize his anger in a firm but nonprovocative manner.

There are three stages in Assertiveness Training. In the first, the therapist explains the rationale for assertion, pointing out the ways in which it is superior to aggression and nonassertion and the harmfulness of those modes of responding. This phase often involves a degree of cognitive restructuring, as the therapist attempts to modify the client's faulty belief system. In the second stage, the client generates a list of real-life scenarios in hierarchial order of subjective difficulty. The final and most important stage involves behavioural rehearsal, where the therapist and client enact the relevant vignettes. Modelling, roleplay and feedback are vital components. In vivo assignments may also be used.

Of the jurisdictions that replied to our letter of inquiry, four (8%) reported Assertivenesss Training as part of their treatment approach to violent offenders. The state of Washington utilizes it in two institutions: one for adults and one for juveniles. No evaluative data was forwarded by any of the respondents. Other researchers have found it useful in the reduction of aggressive behaviour (Rimm, Hill, Brown, and

Stuart, 1974; Whiteside, 1976; Wood, 1978; Raleigh,1978; Pentz, 1980; Martinez, 1978). For maximum effect, it should be taught by the Structuring Learning Therapy described earlier (Pentz, 1980; Wood, 1978), and in conjunction with Relaxation Training (Carr and Binkoff, 1981). The ideal candidate is nonpsychotic, of normal intelligence, overcontrolling of his aggressive impulses and experiencing high tension levels.

5. Anger Management

The most comprehensive of the Social Learning approaches, this treatment combines the three major procedures discussed previously: relaxation, cognitive restructuring and inoculation of assertive and adaptive behaviours. It is predicated on Novaco's (1975) model, in which anger is accelerated by a combination of physiological arousal and the labelling of this arousal as anger. Arousal is instigated by distorted expectations and incorrect appraisals of provoking events, which are given representation in language through private speech. Internal sentences and self-statements can serve to both elicit and sustain anger and arousal. Therapy seeks to modify these self-instructions by changing them into calming and task-specific thoughts.

There are four steps to Anger Management, also known as "Stress Inoculation":

1. Relaxation. Initially, each client is taught deep muscle relaxation to help recognize and reduce the agitation and arousal that can disrupt rational cognitions. The physiological "cues" that indicate the onset of arousal (e.g. clenched fists, stomach tension) for each individual are identified. Clients will be taught later to use these cues as an signal for initiating calming and self-reinforcing internal dialogue.

2. Cognitive Learning and Restructuring. In this stage, the client is educated about anger and its components (e.g. the circumstances that typically evoke anger, the role of faulty belief systems, the benefits of assertiveness etc.). At Washington's Special Offender Center, this stage includes in-depth discussion of the ways in which the prison environment encourages violence.

3. Self-instruction skills. Calming and self-reinforcing internal sentences are taught by SLT. Internal dialogue should follow four steps: i) planning in advance how to handle a provoking situation; ii) confronting the other person assertively, iii) coping with physiological arousal; and iv) self-reward for successful resolution. Of these, the third step is considered the most important.

4. Application Training. The client practices all that he has learned in hierarchicly arranged imaginal, role-played, and/or real-life siuations.

Anger Management has been used effectivly with law enforcment officers (Novaco, 1977), juvenile delinquents (Shrader, Lang, Panzer, Gillet and Kornblath, 1977; Bowman 1979; Morris, 1981; Schlicter and Horan, 1981) and with aggressive adult offenders (Petrella, 1978; Atrops, 1979; Fink, 1981; Mann, 1982; Gaertner, 1983). It was used in 8 (16%) of the responding jurisdictions. Preliminary reports were available from two (see Appendicies E and F). In both, imates involved in Anger Management Programs showed encouraging decreases in aggressive and abusive behaviour. Inmates selected for this kind of treatment should have obvious deficits in impulse control and provocation management skills. Moreover, it appears that the higher the intelligence of the trainee, the greater the benefits received.

C. Counselling Services

A number of the jurisdictions (20%) reported the provision of "counselling services" among their treatment strategies for the violent offender, often without further explication.

Presumeably, these services do not systematically employ the specific contingency management or social learning approaches described previously. Instead, they focus on client self-awareness and insight. Efforts are directed at developing a client-therapist relationship that encourages rapport and facilitates disclosure. Examination of the client's subjective experiences, current behaviours and motivating emotions is thought to bring about constructive self-change. Although it has been effective with some disorders, this kind of therapy seems to have limited effectiveness on the demonstration of overt aggression (Goldstein, 1981; American Psychiatric Association, 1974).

Counselling therapies are roughly divisible by the particular period in the client's life on which they put their emphasis, whether past, present or future. Two examples of "background oriented" therapies were evinced in the surveyed jurisdictions.

i. Psychoanalysis. A legacy of Freud's, this therapy typically scrunitizes the traumatic events in the client's childhood or adolescence. Repressed or forgotten memories and their related emotions are recalled through verbalizaton or reenactment of the original event. This is presumed to allow catharsis of latent anger and hostility. It was reported by only one jurisdiction.

Abreactive treatments of this kind have been subject to considerable criticism (Bandura, 1973; Zillman, 1978). Evidence indicates that imaginal recreations of anger-provoking images without concurrent counterconditioning leads to a disinhibition of restraint against aggression, and may actually increase violent behaviour (May and Johnson, 1973; Rimm and Litvak, 1969).

ii. Criminal History Review. This therapy was offered at Washington State's Cascade Program for juveniles convicted of violent offences. It is described as an "offence-specfic treatment" in which the individual's pre-conviction history is scrutinized to determine his personal crime pattern. Self understanding and a recognition of the internal and external forces that instigate and sustain criminal activity are stressed. Although no evaluative data was provided for this therapy, an overall assessment of Cascade indicated a decrease in program recidivism among participants.

Only one jurisdiction utilized a "present-oriented" counselling service. Developed by Glasser (1965), Reality Therapy emphasises "the here and now"and refuses to accept past history as an unrelenting determinant or excuse for current behaviour. Clients are encouraged to accept resonsibility for themselves and their actions, and to develop sufficient

self-discipline to deal realistically with their problems. It has been used effectively with delinquency-prone adolescents (Epstein and Maragos, 1982).

Teleological, or future-oriented therapies, were not described by any of the jurisdictions in the sample. In essence, these treatments encourage clients to verbalize their goals and life priorities, consider alternatives, and to make carefully deliberated decisions. Criminal and aggressive behaviour may be amenable to therapy of this kind, particularly if it includes systematic training in problem-solving skills (Goldstein, 1981).

D. Group Therapies

As with individual counselling, group therapy can be non-directed and disclosure-related; or it can be a vehicle for a specific treatment strategy. Social Skills Training, for example, is ideally suited to group instruction. Individual and group therapies are not necessarily mutually exclusive: The individual-directed techniques described earlier (i.e. relaxation, stress inoculation) are often taught "en masse". Group practices can be tailored to the individual. The advantages of group therapies are many: it is financially and

physically more economical; it allows more opportunities for observation, modelling and rehersal; and it can help to mobilize peer-influence in favour of the treatment goals. The latter implication is of particular importance in the prison environment, where group pressures and social influences are strong determinants of inmate attitudes and behaviour (Toch, 1969). With violent inmates, small homogeneous groups at similar levels of mental ability are desirable, as this tends to lessen rivalry and antagonism (Meers, 1979). Ten of the 50 respondents (20%) in the survey sample were currently running a group therapy program. Of these, 8 (16%) used general group discussion aimed at encouraging disclosure and support. Five jurisdictions (10%) taught the previously described social learning therapies in a group context.

Some of the jurisdictions used modified versions of the group therapy concept. These included values clarification, large group alternatives, family therapy, and speech therapy.

1. **Values Clarification**

This therapy technique, used in the jurisdiction of Washington's Cascade Program, is derived from the literature on moral education. Aggressive juveniles, according to the conceptual orientation, are chronic and irrational dissenters

from the norms of society. Lacking their own value system, they gain identity by opposing and oppressing others. Values clarification seeks to teach recipients a process of evaluation by which they can develop and clarify their own values. Elimination of value confusion should lead to a reduction in destructive behavior and a concommitant increase in constructive action and self-esteem. Youths must be allowed to freely choose their value systems; there must be no attempt to indoctrinate them (Raths, Harmin and Simon, 1966).

Values clarification is taught in a classroom or small group setting. Ideally, value selection progresses through three stages, each with its associated techniques:

a. Choosing. This is the cognitive component of VC. The teacher emphasizes free generation of alternatives and careful consideration of the consequenses of each option. Techniques to facilitate this process include questioning and discussion, ranking of personal priorities and reflection on "moral dilemma" vignettes.

b. Prizing. In this affective stage of V.C., clients are encouraged to "cherish" or feel proud of their values, and to be willing to publicly affirm them. Each is given an opportunity to discuss their beliefs in a public interview before the group.

c. Acting. This is the final, behavioural phase of the training. The clients are exhorted to behave in accordance with their chosen values, and to do so repeatedly and consistently in day-to-day life. In-vivo assignments and role-playing are used as training techniques.

Empirical support for V.C is tentative. Its inventors claim some success in supplanting destructive behaviours with constructive actions in serious juveniles (Raths et al.,1966); however, this research has been severely criticized. The concept of "value relativity" implicit in its theoretical underpinnings has also been denounced as morally and philosophically indefensible (Edelman and Goldstein, 1981).

2. Large Group Alternatives

One of institutions in the survey, the Special Care Unit in New South Wales, Australia, used four modifications to the group concept above and beyond the group therapy they already employed.

a. Community meetings, where inmates and staff assemble to discuss issues of concern to themselves and the unit (e.g. allocation of work roles, resolution of interpersonal

conflicts, etc.). (A similar arrangement existed in one other jurisdiction).

b. Crisis meetings, which are specially convened meetings which can be called by any member of the community, usually to deal with suspected violations of community rules (i.e. drug use, inmate assault) or perceived victimization of inmates by staff.

c. Communication and Debating Group, where inmates learn the relevant skills and compete in internal and local competitions.

d. Job Skills Group, where inmates meet to learn job search and interview skills, as well as to discuss work-related problems.

Of these, only community groups demanded compulsory attendance. A general description of these large groups provided by the SCU indicated that they were generally successful. Inmate suspicion and antagonism towards staff was considered the most salient obstacle to complete efficacy.

3. **Family Therapy**

This "atypical" rehabilitative therapy was operative in one jurisdiction, at Patuxent Prison in Maryland. Although it is not rare in the world of counselling, family therapy is not

documented as a treatment for violent offenders in any other jurisdiction, or in the relevant literature. All the members of the inmate's immediate family, both alone and together, are interviewed by the therapist, and any salient problems confronted. Particularly valuable in cases of spouse or child abuse, family therapy may also be desirable for those inmates pending release.

4. Speech Therapy

Auditory, reading and speech disabilities have been associated with the development of aggression in some individuals (Bryant, 1982; King, 1975). One jurisdiction (Maryland, at Patuxent) provides diagnostic evaluation and treatment for disorders of that kind. No literature is available on the efficacy of speech therapies with violent offenders.

Summary

Treatments oriented towards changing the individual violent offender were relatively frequent among the 50 respondent jurisdictions. Of those reporting non-traditional methods, counselling services and social learning approaches were the most common interventions. None of the jurisdictions described their selection criteria for candidates to the various

treatments. Given that aggression has a diverse number of causes and manifestations, the development of strategies to address the heterogeneity of violence is of critical importance; therapists must assess the reasons underlying the behaviour of the individual inmate before assigning him to a particular therapy. Contingency management seems most effective in cases of mental deficiency and acute psychosis. The social learning approaches are best suited to inmates having pronounced skill deficits in prosocial behaviour, impulse control, accurate interpersonal or self perception, and/or provocation management. Because of their emphasis on cognitive restructuring and memory processes, candidates for social learning should be of normal intelligence, free of gross perceptual disturbances, and motivated to master the relevant skills. Virtually all forms of individual therapy and counselling can be modified to adapt to a group format. This allows for the involvement of social and peer influences in the therapeutic context. The primacy of the social milieu in the control and encouragement of prison violence has been extensively examinined by some researchers (Toch; 1980; Ellis et al., 1975). Changing the individual is only half the picture: effective interventions should also attempt to influence the prison's social organization. It is to these kinds of strategies that we turn our attention in the next section.

III. MODIFYING THE SOCIAL ENVIRONMENT

The common denominator in the following intervention strategies is their focus on the staff/inmate interface as the critical unit of change. In order to alter the violent offender, one must first remodel his social milieu. Occasionally, this entails alterations in the physical setting as well; as a result, most of these modifications are conducted in separate prison units or separate facilities. Given the importance of social climate and control within the prison environment, communication between staff and inmate subcultures is essential for institutional harmony and effective rehabilitation.

Five jurisdictions (10%) out of the 50 responding made use of separate functional units to treat violent prison inmates. Six (12%) transferred disruptive offenders to separate treatment facilities. There are a number of advantages to these arrangements. First, it protects the general prison population. Second, it allows for more intensive application of treatment therapies than would be otherwise possible. Decentralization of the institution's administrative hierarchy allows those most in touch with inmate needs to make treatment decisions. Functional units and separate facilities, by virtue of their smaller size, reduce the fragmentation of service delivery, improve

inmate/staff relations, and promote group cohesiveness and staff morale (Smith, 1977). Within the special institutions surveyed, a number of related interventions were reported: these were inmate contracting, privilege stratification models, therapeutic communities and inmate staffing arrangements.

1. Contracting

Contractual agreements between inmates and staff define the conditions of involvement in a particular treatment program, as well as the gains and contributions the inmate is expected to make. It begins upon the inmates admission to the unit, when he confers with staff members to determine realistic goals for improvement. A list of objectives is developed, stated in specific measurable terms. Advancement through the phases of the program is marked by accomplishment of these goals. Continuance and release are contingent on compliance with prison rules and participation in mandatory activities. The distinction between contracting and traditional rule-enforcement and individualized treatment plans lies in the inmate's contribution to his own progress; he is an "equal partner" in the decision-making process. Moreover, he has the option to discontinue his involvement in the overall program at set intervals. Either party can suspend or modify the contract, subject to certain conditions.

Three of the responding jurisdictions (6%) used contracting as a therapeutic tool. At the Federal Correctional Institute at Butner, North Carolina, the inmate moves through four phases, with privileges and responsiblities increasing at each stage. The treatment contract stipulates that a decision to continue must be made at the end of the first two stages; afterwards, the inmate is committed to finish. An evaluative report made of the Butner system indicated that inmates were dissatisfied with their degree of involvement in treatment planning; they felt they were permitted only a "token" contribution (Ingram, 1978). A more developed system was evinced at Washington's Cascade program for juveniles. New goals are set upon accomplishment of those initially planned; in addition, objectives must be met in a specific time interval. The Special Care Unit in New South Wales utilizes the most sophisticated version of contracting. Negotiation and goal refinement take place over a series of pre-admission interviews. Once inside, the inmates are compelled to complete a mandatory self-assessment schedule at regular intervals. He must prepare a written document detailing his present self-concept, his involvement in unit programs, and his post-release plans. He must present it to an assessment panel composed of both staff and inmates. To deter the manipulative inmate who seeks the benefits of SCU's benign environment, all contracts specify a maximum length of stay. If improvement is

not evident by a certain period, the inmate is transferred back to the general population. A descriptive report of SCU's contracting methods indicates some success in improving staff/inmate relations (Bailey and Schwartz, 1982).

2. Privilege Stratification Models

Somewhat related to contracting methods, privilege stratification systems grant increasing levels of reward, liberty and opportunity for continued good behaviour. The prescribed levels can be applied globally throughout the institution, or they can be isolated geographically through the use of discrete units or "tiers".

a. Levels throughout the institution

Two jurisdictions (4%) used a system of graduated progression through treatment phases. Admission to each phase is associated with increased privilege and responsibility. However, inmates are not relocated to new living quarters for each successful graduation; their status is indicated by identification cards or tags. The FCI at Butner, North Carolina and the Cascade Program at Washington are examples of this type of phase-related privilege stratification.

Similar models are found in the research literature. The START (Special treatment and rehabilitative training) program was developed in the early 70's for violent inmates who could not be assimilated into the general inmate population. Of the 19 who were admitted into the START facility, ten successfully completed it. Despite the 50% success rate, considered exceptional for this type of offender (Scheckenbach, 1974;75), the program was discontinued due to the difficulty of acquiring inmates who met the admission criteria (Carlson, 1974).

Increased privilege need not be the currency on which such interventions are based. Keltner and Gordon (1976) demonstrated that the return of lost statutory remission can serve as an effective reward with violent inmates. Each 24 hour period free of charge was reinforced by the return of one third of a day of lost remission, over a period of 30 days. Infractions resulted in the loss of all earnings accrued during each 30 day period; they could, however, be reinititated. Significant reductions in hostile and assaultive incidents resulted from this practice.

b. Tier Systems

This type of stratification model is ideally suited for violent inmates with severe mental or behavioural disorders. Three jurisdiction (6%) utilized this system in which all inmates at a certain level of mental functioning or adjustment

are housed together. Graduation from each tier is contingent on improvement or remission of psychotic symptoms.

In the jurisdiction of Florida, two tier system interventions are used: Close Management for disruptive inmates, and the W-Wing of the State prison for those with serious mental illnesses. The former is a program of long-term single-cell accommodation into which inmates are placed after serving initial disciplinary segregation. There are two levels of close management, with the second associated with greater privileges. In the W-Wing, acutely psychotic inmates with at least one violent conviction are stratified into three tiers corresponding to their level of recovery. Although details were not provided, it was indicated by the jurisdiction that the majority of inmates who have progressed through W-Wing have made significant improvements.

The Special Offender Center at Munroe, Washington is an independant correctional facility with four sub-units. Unit 1 provides short-term psychiatric care for the acutely disturbed. Once the major symptoms of mental illness are controlled, the inmate may progress on to Units 2 and 3, where the emphasis is on training inmates for reentry into the community or less restrictive environments. Unit 4 is independent of the other three; it is designed specifically for the non-disturbed inmate with a history of serious sexual or assaultive offences. The SOC did not forward any evaluative data on its tier system.

Patuxent prison in Maryland employs a tier system that has come under considerable empirical scrutiny. It has two separate but parallel programs for violent and mentally ill offenders. Divided into four privilege tiers, Patuxent also has four "units" which cut across the tiers. When an inmate enters Patuxent, he is assigned to one of these units, each of which is headed by a team of psychiatrists and social workers. The inmate remains in continuous contact with the same unit as he progresses through the tiers. An evaluative study conducted in the early 70's (Hoffman, 1977) led Patuxent to modify and upgrade its treatment program. Subsequent studies (Holden, 1978) indicated an improvement in service delivery. Early data on recidivism is also encouraging.

3. Therapeutic Communities

Separate facilities or functional units can sometimes be designed to meet the criteria for a therapeutic community. The latter is generally defined as a semiautonomous environment which encourages the development of an internal social system facilitative of staff/inmate communication. This can be realized via a number of components (Toch, 1980b, Jones, 1980):

a. Regular meetings of community members, where decisions regarding the community are made by consensus;

b. Collaborative activity in the form of shared labour and responsibility (often concerning the maintenance of shared assets);

c. An emphasis on group solidarity and morale; mutuality and disclosure are encouraged in an atmosphere of free expression;

d. An inverse relationship between responsibility and growth of the inmate clients and the degree of staff intervention; and

e. A manifestly secure perimeter, with relatively relaxed coercive control within the community.

Of the institutions described by the surveyed jurisdictions, two (4%) qualify as therapeutic communities: the FCI at Butner and the SCU at New South Wales. The report forwarded by the latter (Bailey and Schwartz, 1982) describes a reduction in violent inmate behaviour. Butner's therapeutic community has been empirically evaluated (Love and Ingram, 1982; Levinson and Dieppe, 1976; Ingram, 1978; Ingram, 1980). The findings suggest that violent inmates sent to Butner commited no more infractions than did a control group in the general population. Moreover, enrollment in voluntary programmes was significantly higher in the Butner sample. The investigators attribute the success of this model facility to the open and credible communication between staff and inmates (Ingram, 1978).

Therapeutic communities described in the literature receive similar commendations. Assaultive behaviour in violent juveniles

has been significantly reduced by this method (Tate, 1980). The Barlinnie Prison in Glasgow, Scotland, was considered the model therapeutic environment for violent inmates. (It had been discontinued by the time of the study). When staff worked with the eight specially selected inmates without regard for traditional roles, incidents of violence disappeared (Whitehead, 1979). Evidence also indicates that TC's have a favourable influence on inmates' perception of the psychosocial environment and self-reported hostility (Beard, 1980). However, care must be taken to select the appropriate participants for a therapeutic community or any special environment (Porporino and Marton, 1983). The ideal inmate candidate is verbal, responsive to social influences, and motivated toward development of their individuality (Briggs, 1980).

4. Inmate staffing

This approach seeks to penetrate and modify the inmate subculture by developing a new basis for social status among prisoners. Inmates held in high regard by both staff and other inmates are selected and carefully trained in leadership and related techniques. They are then involved in the implementation and operation of various treatments and activities in the institution. Ideally, peer influence on fellow inmates grows in a positive and controlled direction leading to beneficial social involvement and self-improvement.

Two jurisdictions (4%) of the 50 who responded utilized inmate staffs in their prisons. The SOC in Munroe, Washington, offers this opportunity only to senior inmates at the highest level of privilege; they assist in activity program implementation. Care is taken that they do not exercise control over other inmates through decision-making or access to confidential information. The jurisdiction of Florida has imported the services of an external agency, the GOLAB, with a somewhat different approach. After a rigorous screening process, inmates of high calibre are trained through a series of workshops. They are given virtually total responsibility for the activity sessions they conduct, often without the presence or assistance of correctional officers (see Appendix G for details). Its exponents cite the fact that in six years of operation, the GOLAB has not experienced " the slightest adverse incident of any type" as testament to its efficacy. Although recommended as a intervention in corrections literature, inmate staffing has not been empirically evaluated.

Prisoners and guards have a tendency to form mutually antagonistic subcultures (Charles, 1980). Attempts to resolve the consequent communication deficits often take the form of modifications to the prison's social organization. Occasionally this may include increased inmate involvement regarding personal

or environmental decisions, as in contracting and therapeutic community models. Sometimes it is the incentive stucture of the inmate subculture that is addressed and altered, as in privilege stratification or inmate staffing. In either case, the social milieu of the violent offender is considered vital to the management and control of aggression and hostility within the prison. Yet the inmate side is only half of the equation: staff processes are also involved. The importance and the training of correctional staff thus become the subject of the next section.

IV. STAFFING THE INSTITUTION

Staff training and selection is one of the methods by which some jurisdictions attempted to improve staff/inmate relations and reduce prison violence. The violent offender poses a special problem: a special staff must be produced to deal with him (Johnson, 1977, 1979, 1981; Toch, 1980a ; Danto, 1979). Of particular interest is the custodial officer, a neglected resource in the correctional system (Porporino and Marton, 1983; Ross and Mckay, 1981). They have the most contact with inmates and hence the greatest potential for positive and effective interaction (Toch, 1980a). A vital source of information about inmate networking and behaviour, guards should be an integral part of policy and program planning. Moreover, security personnel are most often the witnesses or targets of aggression; they require special training in crisis intervention and evaluation of hostile prison atmosphere (Toch, 1975).

Four (8%) of the surveyed jurisdictions had developed particular staff training programs to deal with violent inmates. In one jursidiction, training was reserved for professional staff only - social workers and psychologists to establish consistency in therapy techniques. The remaining three jurisdictions focused on the development of the custodial officer as an human service delivery agent. Only one, the SCU in

New South Wales, employed a prescreening process. Applicants to staff positions had to undergo a battery of psychological tests and a comprehensive interview. Assignment to the unit is probatonary, with an option to renew after one year. After their time at SCU, these guards return to the general prison system. In this way knowledge and benefits of training is disseminated throughout the Australian correctional system. Voluntary assignment to programs of this kind seems to be the most effective practice: it has been associated with higher program involvement, increased staff morale and more sophisticated application of training principles (Johnson, 1979).

The specific nature of the training provided in the jurisdictions can be subsumed under three categories: conflict management, crisis intervention, and instruction in group dynamics.

1. Conflict Management

Conflict Management Training enables an officer to anticipate, prevent and react to conflict situations in an effective and nonprovoking manner. The instruction can be outlined in four steps (Porporino and Marton, 1983).

i) Instruction in the typical components of conflict (e.g. polarization, escalation), the different types and functions of aggression, and the role of environmental and social influences on the latter. Eradication of misinformation and sterotypes concerning the violent offender should be a priority of this stage.

ii) Instruction in Conflict Mapping and Prevention. Staff are taught how to recognize indicators of incipient conflict (e.g. elevated levels of social hostility, alterations in inmate activity patterns, cumulative trends in minor incidents etc.) Analysis of the issues, facts and values involved in the history of an ongoing disturbance is necessary to ascertain the appropriate intervention techniques.

iii) Inoculation of specific intervention skills. Interposition, negotiation, communi ations clarification and calming techniques are taught by the social learning process described earlier.

iv) Training in the methods of encouraging, reinforcing and supporting desirable social behaviour among inmates. This may take the form of contingency management, or perhaps instruction of inmates in conflict management skills.

Two jurisdictions (4%) offered conflict management training to their custodial staff. Bailey and Schwartz' (1982) report on the SCU in New South Wales, affirms the effectivness of this approach in both reducing inmate violence and achieving staff solidarity. The pragmatic focus of such specifically formatted instruction was welcomed by institutional staff in other empirical evaluations of conflict management(Rice, Helzel, Varney, and Quinsey, 1984; Johnson, 1981). It has been used effectivly with police officers (Bard and Zacker, 1976) and psychiatric staff (Feld, 1977). Special consideration should be given to the introduction, coordination and crediblity of Conflict Management Training in the correctional institution (Porporino and Marton, 1983).

2. Crisis Intervention

Research has indicated that personal crisis often precede self-injury, suicide and violence directed at others (Toch, 1975). Crisis intervention secks to reach the acutely troubled inmate before the manifestation of destructive behaviour, and to teach him more effective means of coping with personal problems (Lazarus and Laurnier, 1978) Immediacy of treatment is crucial. Front-line staff members are obvious candidates for helping in cases of inmate breakdown (Toch,1980a). In crisis intervention training, correctional staff are taught to recognize the symptoms of severe stress and mental or behavioural disorder.

Ideally, crisis intervention training also includes a section on counselling techniques, so that the staff member can apply emergency assistance to the desperate inmate. Two jurisdictions (4%) provided crisis intervention training: only one (the SCU) gave staff systematic instruction in specific counselling techniques. The development of a collaborative human service delivery system within prisons is thought to reduce stress on both staff and inmates and break down the barriers to effective interaction between the two (Johnson and Price,1981; Johnson and Toch, 1982). Katsampes (1975) has demonstrated that correctional officers can learn to develop autonomous, constructive responses to violent prisoners via this kind of training.

Crisis intervention and human service delivery can be facilitated by a further modification to staffing: the multidisciplinary team approach. Custodial and therapeutic personnel have traditionally misunderstood each other, forming mutually antagonistic subgroups within the staff community (Johnson and Price, 1981). To counteract the detrimental effects of this polarization, a shared training program is implemented that encourages treatment and custodial workers to view themselves as colleagues with cooperative roles to play in the achievement of commons goal. Personnel are educated about "the functional linkages among tasks, the prison ecology, and

the orientation of prison organization" (Johnson and Price, 1981, p. 368). Afterwards, consultation meetings involving all staff members are held regularly; the coordination and consistency of human service delivery, as well as staff morale and solidarity, is enchanced. Responsibility for the success of a unit or program is shared among all staff members. Four (8%) jurisdictions of the 50 that responded to our letter of inquiry fostered a "team approach" to the management of the violent inmate. One, the SCU in New South Wales, went a step further by instituing a group therapy program developed specifically for staff members. Treatment and correctional officers discuss personal and work-related stresses in an atmosphere of mutual respect and support. Both the training and the therapy were well recieved by SCU personnel (Bailey and Schwartz, 1982).

3. Group dynamics Instruction

To maximise the effectiveness of correctional officers as leaders of group therapy programs, two jurisdictions (4%) trained these staff members in group dynamics. Subgroup formation, status hierarchies, power assymetrics, group communication patterns and similar group-related phenomena are studied, and methods to deal with them effectively are discussed. Particularly important in the preparation stages of a therapeutic community, group dynamics training has been proven effective in the handling of persistant "disruptive leaders" who threaten the communities social order (Crabtree, 1982).

Summary

Special staff training and selection procedures were rare in the 50 surveyed jurisdictions. Despite the importance laid upon it by researchers in corrections, few institutions made an effort to modify the prison social organization by altering the role of staff members. Those that did, however, attempted to embellish the role of the corrections officer, making him more responsive to inmate needs and problems. Broadening the scope of custodial workers in conflict management, crisis intervention and group dynamics enables them to interact more effectively with inmates. Training also elevates their status in the staff community, and helps to ameliorate the factionalism that impedes joint staff efforts at rehabilitation.

V. PROVISION OF ACTIVITIES APPROACH

Although the letter sent out to the jurisdictions requested information about therapeutic treatments to the violent offender, 12% of the respondents included descriptions of their activities programs. This would seem to indicate a common perception that these programs counteract inmate violence by virtue of their diversionary properties. Due to the frequency with which these descriptions occurred, a separate section presenting them is warranted.

Prisoner education has four implicit goals: broadening their social awareness, increasing their marketability after release, supplanting antisocial goals and rewards with prosocial values, and providing a meaningful activity to occupy the prisoner's time. Lack of education is considered a key factor in street crime (Johnson, 1966). Four jurisdictions (8%) in the sample indicated they provided inmates with the opportunity to upgrade their education. Generally speaking, these programs imported instructors from the community to work with aggressive individuals on a semi-individual basis. As yet, none had attempted study-release at adult education or colleges off the prison grounds. Drug and Alchohol abuse has been identified as a factor in some violent offences (Blacker, 1970; Fitzpatrick, 1974; Ellinwood, 1971: cited in Austin and Lettieri, 1976). Two

jurisdictions (4%) offered substance abuse education to interested inmates.

Vocational Training and prison industries provide meaningful structured activity for inmates, and enables them to attain marketable skills and work experience. Agriculture, food service, maintenance trades, automechanics and clerical training was provided in five (10%) jurisdictions. Community-located work release were available in two jurisdictions. As a note of interest, the empirical study conducted at Butner, North Carolina (Ingram,1978) reported that the greatest source of dissatisfaction among inmates was the absence of a prison industry.

Only one jurisdiction (Maryland) specified religious services and pastoral counselling as a key component of their therapeutic efforts directed at the violent offender.

Recreational and exercise facilities were described by three (6%) jurisdictions. The underlying notion is that physical activities allow the aggressive inmate to "blow off steam". Only one jurisdiction (Washington) reported implementing intramural sports programs.

CONCLUSION

This report has documented several countermeasures to prison violence that other jurisdictions and corrections researchers have found both effective and feasible. The countermeasures are not an exhaustive list of the potential solutions to the problem of prison violence. However, they do illustrate the diversity of ways in which the issue can be addressed. No single approach will prove universally effective. The very complexity of the problem demands a sophisticated, multifaceted response. To formulate an effective strategy, one must take into account the mutiplicity of environmental and social-psychological factors underlying the phenomenon. Violence can be instrumental in innumerable ways; only by a clear understanding of aggression and the functions it serves for the individual can it be combated.

Global catagorizations and attributions are inappropriate. Punitive and psychiatric measures, although valid in their own right, require supplementary programs. Contingency management and social learning models provide promising alternatives and workable options. Special care must be taken to match the appropriate intervention to the disruptive inmate: differential treatment is essential for optimum change to occur. Ideally, a variety of treatments are offered in an environment that intergrates them within the context of a modified social structure. Alterations to the prison social ecology,

(particularly in the form of staff training in crisis intervention and conflict management) can create a safe, nonhostile milieu that will foster the gains made in therapy. They can bring subtle pressure to bear on the subcultural norms that reinforce violence and destruction. Such comprehensive countermeasures are in fact preventative strategies, mitigating the conflict and hostility in which violence has its source.

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APPENDIX A

LETTER OF INQUIRY

July 5, 1983.

Our File No. 7302-36.

The Research Division of the Solicitor-General of Canada is presently reviewing treatment programs for violent prisoners. Traditionally, institutional programs for violent prisoners have been primarily security oriented (e.g., administrative segregation). The purpose of our review is to identify programs that have shown promise in the treatment of certain types of violent prisoners (e.g., behaviourally oriented temper-control or interpersonal skills programs). In the near future, we hope to initiate several projects to evaluate the effectiveness of such programs as alternatives to traditional security measures.

Accordingly, we are writing to request copies of reports (published or unpublished) that you may have prepared on the subject of treatment programs for violent prisoners in your jurisdiction. Also, if you are aware of any particularly promising treatment programs that have been implemented in other jurisdictions, we would appreciate it if you would let us know.

We would be grateful for your assistance in this matter.

Sincerely,

Frank Porporino,
Senior Research Officer,
Programs Branch, 11th Floor,
340 Laurier Avenue West,
Ottawa, Ontario.
Canada. K1A 0P8.

APPENDIX B

JURISDICTIONS RECEIVING LETTER/JURISDICTIONS RESPONDING

INTERNATIONAL JURISDICTIONS

N - Response
NR - No Respons

NR 1. Institut Fur Strafrecht und Kriminologie, Vienna, Austria

R 2. Correctional Services Department, Adelaide, South Australia

R 3. Australian Institute of Criminology, Canberra, Australia.

R 4. Correctional Services Division, Darwin, Northern Territory, Australia.

NR 5. Special Care Unit, New South Wales, Australia.

R 6. Correctional Services Division, Melbourne, Australia.

R 7. Department of Correctional Services, Melbourne, Australia.

R 8. Department of Corrections, Perth, Western Australia.

R 9. Department of Corrective Services, Sydney, Australia.

NR 10. Centre National De. Criminologie, Bruxelles, Belgium.

NR 11. Research Institute of Criminology, Prague, Czechoslovakia.

NR 12. Ministry of Justice, Copenhagen, Denmark.

NR 13. Research & Planning Unit, Home Office, London, England.

NR 14. National Centre for Social Research, Gezira, Egypt.

NR 15. Ministry of Justice, Helsinki, Finland.

NR 16. Research Institute of Legal Policy, Helsinki, Finland.

NR 17. Institut De Sciences Criminelles De Montpellia, Montpellier Céedex, France.

R 18. Service D'Etudes de Rechercehes Penitentiaries, Paris, France.

R 19. Centre de Formation Permanente, Section de Science Criminelles, Strasbourg, France.

R 20. Institute for International & Comparative Criminal Law, Freiburg, Germany.

NR 21. Institut Fur Kriminologie Der Universitat Heidelberg, Heidelberg, Germany.

NR 22. Institut Fur Kriminologie Der Universitat Tubingen, Tubingen, Germany.

International Jurisdictions (Con'd.)

NR 23. Department of Criminology, Westphalia University, Munster, Germany.

NR 24. Institute of Criminal Sciences, Thessaloniki, Greece.

NR 25. Department of Corrections, Agana, Guam

R 26. Hong Kong Prison Department, Hong Kong.

R 27. Institute of Criminology & Forensic Science, Government of India, New Delhi, India.

NR 28. National Centre for Social & Criminological Research, Baghdad, Iraq.

NR 29. Institute of Criminology, Jerusalem, Israel.

NR 30. International Centre for Clinical Criminology, Geneova, Italy.

NR 31. Centro Studi Sui Compartamenti Devianti, Bologna, Italy.

NR 32. Training Institute for Correctional Personnel, Tokyo, Japan.

R 33. Ministry of Justice, Tokyo, Japan.

NR 34. Centro Penitenciarro Del Estado De Mexico, Estado De Mexico.

NR 35. Criminological Institute, The Netherlands.

R 36. Ministerie Van Justitie, Gravenhage, The Netherlands.

NR 37. Ministry of Justice, Research & Documentation, The Hague, The Netherlands.

R 38. Dr. W. Buikhuisen, University of Leiden, The Netherlands.

R 39. Ministry of Justice, Research & Documentation Center, Rijswijk, The Netherlands.

R 40. Department of Justice, Wellington, New Zealand.

NR 41. Institute of Criminology & Criminal Law, Oslo, Norway.

NR 42. Bureau of Prisons, Rizal, The Phillippines.

R 43. The Institute of Crime Problems, Warszawa, Poland.

NR 44. Administration of Correction, San Juan, Puerto Rico.

R 45. Criminological Research Branch, New Edinburgh, Scotland.

NR 46. Instituto do Criminologia, Madrid, Spain.

International Jurisdictions (Con'd.)

NR 47. Escuela de Estudios Penitenciarios, Madrid, Spain

NR 48. National Prison & Probation Administration, Norrkiping, Sweden.

NR 49. The Swedish Institute, Stockholm, Sweden.

NR 50. Groupement de Travail Pour La Reforme, St. Gall, Switzerland.

NR 51. Criminal Problems Research Centre, Taipei, Taiwan.

NR 52. Department of Corrections, Research & Planning Division, Bangkok, Thailand.

NR 53. Institute of Criminology, Cambridge, United Kingdom.

NR 54. Centre National D'Etudes, et de Rechereches Penitentiaires, Paris, France.

Summary

A total of 54 contacts were made, 20 responded (37% responded)

APPENDIX B

JURISDICTIONS RECEIVING LETTER/JURISDICTION RESPONDING

R - Response
NR - No Response

UNITED STATES

R 1. State Department of Corrections, Montgomery, Alabama.

NR 2. Division of Adult Corrections, Juneau, Alaska.

NR 3. Planning, Research & Program Services, Department of Corrections, Phoenix, Arizona.

NR 4. Department of Correction, Pine Bluff, Arkansa.

R 5. Department of Corrections, Sacramento, California.

R 6. Stanford University (Re: Professor G. Bower), Stanford, California.

NR 7. Stanford University Library, Stanford, California.

R 8. U.S. Department of Justice, National Institute of Corrections, Boulder, Colorado.

NR 9. Department of Corrections, Colorado Springs, Colorado.

NR 10. Department of Correction, Hartford, Connecticut.

R 11. Department of Correction, Smyrna, Deleware.

NR 12. Department of Corrections, District of Columbia.

R 13. Department of Corrections, Tallahassee, Florida.

R 14. Florida State Prison, Starke, Florida.

R 15. Department of Offender Rehabilitation, Atlanta, Georgia.

NR 16. Department of Social Services, Corrections Division, Honolulu, Hawaii.

NR 17. Department of Corrections, Boise, Idaho.

NR 18. Center for Studies in Criminal Justice, Chicago, Illinois.

R 19. Professor M. Cherif Bassiouni, DePaul University, Chicago, Illinois.

NR 20. Department of Corrections, Springfield, Illinois.

NR 21. Department of Correction, Indianapolis, Indiana.

NR 22. Division of Adult Corrections, DesMoines, Iowa.

R 23. Department of Corrections, Topeka, Kansas.

APPENDIX B

United States Jurisdictions (Con'd.)

R 24. Kansas State Reception & Diagnostic Center, Topeka, Kansas.

R 25. Corrections Cabinet, Frankfort, Kentucky.

R 26. Adult Corrections, Baton Rouge, Louisiana.

NR 27. Correctional Programs, Department of Corrections, Augusta, Maine.

R 28. Department of Public Safety & Correctional Services, Towson, Maryland.

R 29. National Criminal Justice Reference Service, Rockville, Maryland.

NR 30. National Institute of Mental Health, Rockville, Maryland.

NR 31. Programs & Treatment, Department of Correction, Boston, Massachusetts.

NR 32. Department of Corrections, Treatment, Institutions, Lansing, Michigan

NR 33. Department of Corrections, St. Paul, Minnisota.

NR 34. Department of Corrections, Jackson, Mississippi.

NR 35. Department of Corrections, Planning & Research, Jefferson City, Missouri.

R 36. Corrections Division, Classification & Treatment, Helena, Montana.

R 37. Department of Correctional Services, Lincoln, Nebraska.

NR 38. Department of Prisons, Carson City, Nevada.

NR 39. New Hampshire State Prison, Concord, New Hampshire.

R 40. Adult Institutions, Department of Corrections, Trenton, New Jersey.

R 41. Corrections Department, SanteFe, New Mexico.

NR 42. Forensic Unit, New Mexico State Hospital, Las Vegas, New Mexico.

R 43. Department of Correctional Services, Program/Health Services, Albany, New York.

NR 44. Great Meadow Correctional Facility, Comstock, New York.

R 45. Wallkill Correctional Facility, Wallkill, New York.

NR 46. John Jay College of Criminal Justice, New York, New York.

NR 47. Federal Correctional Institution, Butner, North Carolina.

R 48. Department of Correction, Programs & Development, Raleigh, North Carolina.

United States Jurisdictions (Con'd.)

NR 49. Director of Institutions, Bismarck, North Dakota.

NR 50. Centre for the Study of Crime & Delinquency, Ohio State University, Columbus, Ohio.

NR 51. Department of Rehabilitation & Correction, Columbus, Ohio.

R 52. Department of Corrections, Division of Programs & Services, Oklahoma City, Oklahoma.

R 53. Corrections Division, Salem, Oregon.

NR 54. Oregon State Hospital, Correctional Treatment Programs, Salem, Oregon

NR 55. State Correctional Institution (Rockview), Bellefonte, Pennsylvania.

R 56. Dr. J.F. Mazurkiewicz, State Correctional Institution, Bellefonte, Pennsylvania.

NR 57. Center for Studies in Criminology & Criminal Law, Philadelphia, Pennsylvania.

R 58. Bureau of Correction, Programs, Camp Hill, Pennsylvania.

R 59. Department of Corrections, Cranston, Rhode Island.

NR 60. Department of Corrections, Program Services, Columbia, South Carolina

R 61. Board of Charities & Corrections, Pierre, South Dakota.

NR 62. Department of Correction, Rehabilitative Services, Nashville, Tennessee.

NR 63. Institute of Contemporary Corrections & Behavioral Sciences, Huntsville, Texas.

R 64. Department of Corrections, Treatment, Huntsville, Texas.

NR 65. Department of Corrections, Program Services, Waterbury, Vermont.

R 66. Department of Corrections, Richmond, Virginia.

NR 67. Association of State Correctional Administrators, Richmond, Virginia.

R 68. Bureau of Corrections, St. Croix, Virgin Islands.

R 69. Washington State Reformatory, Munro, Washington, D.C.

United States Jurisdictions (Con'd.)

R 70. Special Offender Centre, Munro, Washington, D.C.

NR 71. Justice Department, Research & Statistics, Washington, D.C.

R 72. Division of Juvenile Rehabilitation, Olympia, Washington.

NR 73. National Institute of Corrections, Washington, D.C.

R 74. Department of Justice, Bureau of Prisons, Washington, D.C.

R 75. Department of Corrections, Program Development, Olympia, Washington.

NR 76. Department of Corrections, Charleston, West Virginia.

NR 77. Division of Corrections, Madison, Wisconsin.

R 78. Adult & Juvenile Institutions, Cheyenne, Wyoming.

Summary

A total of 78 contacts were made, 37 responded, (47% responded).

APPENDIX B

JURISDICTIONS RECEIVING LETTER/JURISDICTIONS RESPONDING

R - Response
NR- No Response

CANADA

NR 1. Department of the Solicitor General, Edmonton, Alberta.

NR 2. Ministry of the Attorney General, Victoria, British Columbia.

NR 3. Department of the Attorney General, Winnipeg, Manitoba.

NR 4. Department of Justice, Fredriction, New Brunswick.

R 5. Adult Corrections Division, St. John's, Newfoundland.

NR 6. Correctional Services for Juveniles & Adults, Yellowknife, North West Territories.

R 7. Correctional Services for Adults, Halifax, Nova Scotia.

NR 8. Planning & Research Branch, Ministry of Correctional Services, Toronto, Ontario.

R 9. Correctional Services for Adults, Charlottetown, Prince Edward Island.

R 10. Correctional Services for Adults, Regina, Saskatchewan.

NR 11. Correctional Services for Adults, Whitehorse, Yukon.

NR 12. International Centre for Comparative Criminology, Montreal, Quebec.

NR 13. Services pour delinquants adultes, St. Foy, Quebec.

Summary

A total of 13 contacts were made, 4 responded (30% responded).

APPENDIX C

JURISDICTIONS REPORTING COUNTERMEASURES TO PRISON VIOLENCE

I. Traditional Measures

A. Punitive/Administrative segregation

Alabama
California
Delaware
Florida
Georgia
Hong Kong
Illinois
India
Japan
Kansas
Kentucky
Louisiana
Maryland
Newfoundland
New Jersey
New Mexico
New South Wales, Australia
Northern Territory, Australia
Nova Scotia
Oregon
Prince Edward Island
Pennsylvania
Poland
Republic of France
Rhode Island
Saskatchewan
South Dakota
Sweden
Texas
The Netherlands
Virgin Islands
Washington
West Australia
West Germany
Wyoming

Total: 37

B. Psychiatric treatment

Delaware
Florida
Georgia
Kansas
New Jersey
New Mexico
New South Wales
North Carolina
Sweden
Washington

II. Changing the Violent Offender

A. Contingency Management

2. Time Out

West Australia

B. Social Learning Models

1. Social Skills Training

Florida
New Zealand
Oklahoma
Washington

2. Relaxation Training

California
Montana
New Zealand
Oklahoma
Washington

3. Rational Emotive (Behaviour) Therapy

Oklahoma
Washington

4. Assertiveness Training

Montana
New Zealand
Pennsylvania
Washington

5. Anger Management

California
New Zealand
Oklahoma
Pennsylvania
South Australia
Virginia
Washington
West Australia

C. **Counselling Services**

Delaware
Florida
Georgia
Maryland
New Mexico
North Carolina
New Zealand
Pennsylvania
Washington
West Australia

i) Psychoanalysis

New Zealand

ii) Criminal History Review

Washington

iii) Reality Therapy

New South Wales

D. **Group Therapies**

Florida
Kansas
Maryland
Monatana
New Mexico
New South Wales
New Zealand
South Australia
Washington
West Australia

i) Values Clarification

Washington

ii) Large Group Alternatives

New South Wales
North Carolina

iii) Family Therapy

Maryland

iv) Speech Therapy

Maryland

III. Modifying the Social Environment

Separate Functional Units

Florida
Georgia
Kansas
New South Wales
South Dakota

Separate Facilities

Maryland
New South Wales
North Carolina
South Australia
United Kingdom
Washington

1. Contracting

New South Wales
North Carolina
Washington

2. Privilege Stratification

i) Levels Throughout the Insitution

North Carolina
Washington

ii) Tier Systems

Florida
Maryland
Washington

3. Therapeutic Communities

North Carolina
New South Wales
United Kingdom

4. Inmate Staffing

Florida
Washington

IV. Staffing the Institution

Staff screening

New South Wales

Staff Training

New South Wales
Oklahoma (professionals only)
South Dakota
West Australia

1. Conflict Management

New South Wales
West Australia

2. Crisis Intervention

New South Wales
South Dakota

i) Multidisciplinary Team Approach

Florida
Maryland
New South Wales
Washington

3. Group Dynamics

New South Wales
North Carolina

V. Provision of Activities Approach

1. Education

Maryland
North Carolina
Rhode Island
Washington

i) Substance Abuse Education

Oklahoma
North Carolina

2. Vocational Training

Maryland
New South Wales
North Carolina
Rhode Island
Washington

3. Religious Counselling

Maryland

4. Recreation Programs

Maryland
Rhode Island
Washington

APPENDIX D State of Oklahoma Rational Behavior Therapy Program

PRELIMINARY REPORT

THE RATIONAL BEHAVIOR TRAINING PILOT PROJECT

I. INTRODUCTION

The project formally began during the month of November, 1982 and was completed in April, 1983. During the five month period, groups were conducted in five facilities by the following individuals: Brent Crouse (Crabtree), Ben Cumbus, (Oklahoma State Penitentiary), Jan Fesler (Lexington Assessment and Receiving Center), Mike Guttman (Joseph Harp), Jan Henderickson (Conner). Each Rational Behavior Trainer received a minimum of two weeks of training in RBT. The first week involved learning the relevant information including the following: the RBT model, the basic concepts, five rules of rational thinking, rational self analysis format, attitudes and beliefs, rational emotive imagery, working with specific problems areas; e.g., stress management. The second week involved more experiential learning experiences as well as did the third week. The trainers were taught usage of RBT in groups and dynamics of such groups. Video and audio tapes of Dr. Maxie Maultsby were also viewed. Mr. Mike Ruhnow was the principal trainer for the three week training period.

II. METHOD

Exclusion Criteria were established for the project. It had been suggested by Dr. Maultsby as well as others that individuals with certain types of problems respond poorly to Rational Behavior Training. Therefore, individuals with certain deficits were not admitted into the program. The following criteria were established for the group: 70 I.Q., nonpsychotic and no major neurological impairment.

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The RBT program could be delivered to the subjects in a ten to thirteen week period. A frequency of sessions was typically one per week. The trainers manual was constructed to include one module per major area. The program was designed so that participants could practice on constructing RSA's and REI's. There was additional time set for individuals to assimilate the new way of problem solving as set forth by the RBT program. Individual time with the trainer and participant was also allowed and occured in at least some of the groups. Therefore, if a participant was experiencing difficulties in grasping the concepts more time with the trainer was available.

Success for criteria was not consistently established throughout the project. However, most trainers considered mastery of the RSA as adequate evidence for success. The number of RSA's to be successfully completed was also variable from one facility to the next.

Each facility had two groups, a control group and treatment group. Size of groups was also variable, beginning with at least fourteen to sixteen participants.

However, drop out rate reduced the total N to 41 at the completion, 27 in the treatment group and 14 in the control group. Although the treatment groups program was specified, the control group structure was not. The control group were to not receive RBT and, preferably no treatment, unless it was deemed clinically required and urgent.

Placement into either control or treatment group was to be through randomization. Participation was on a voluntary basis. Members in both groups were administered several pretests and posttests including the following: Beck Depression Inventory and Kellner. Several were also administered the IPTIS-A.

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The Null Hypothesis (Ho:) was the following: there would be no significant difference between the control and treatment groups as measured by the pre and posttests. It was decided that since the data obtained for these assessments were ordinal, a nonparametric technique would be used. The statistic decided upon was the Mann-Whitney U. This statistic was calculated in addition to other measures such as the mean and standard deviation.

The following data was obtained:

Beck Pretest-Posttest Difference Scores - Group Mean

Treatment Group	X = -9.51
Control Group	X = -6.28
	Z = .65*
	P = .26

*(Accept Ho: with alpha set at .05)

Kelner Pretest-Posttest Difference Score - Group Mean

	AS+R	SS+SW	D +C	HS+F
Treatment Group	X=-3.95	X=-1.29	X=-4.00	X=-2.38
Control Group	X=-3.39	X=-1.07	X=-2.71	X=-2.35
	Z=.86*	Z=.47*	Z=.20*	Z=.91*
	P=.10	P=.32	P=.42	P=.18

*(Accept Ho: with alpha set at .05)

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DISCUSSION

Interpreting the results of the project is a somewhat tentative task as no statistically significant results occured, in addition to the fact there were several limitations to the study. It is suspected that if certain variables were partialed out, a significant result could be obtained. Three noteworthy client variables to be investigated would be (1) intellectual functioning, (2) expectancy and (3) type and degree of psychopathology.

Intellectural Functioning

Although the criteria for inclusion was a minimum of 70 I.Q., a trend may be seen between higher I.Q. and benefits obtained from the program. Speculation would suggest there is a unilinear relationship if all other variables (such as expectancy and degree of pathology) were held constant; i.e. increased benefits correlate with higher I.Q.'s.

Client expectancy:

This variable includes what the subject desired out of the program and what he thought he would receive. Did the subject expect to learn new verbal behavior or new conceptual behavior? Examples of expecting to learn new verbal behavior would be those subjects who mastered the different aspects of the RSA such as what goes in sections A, B, C, D, etc. and then could construct good RSA's. Examples of expecting to learn new concept behavior would be to understand the concepts the RSA is representing e.g. insight into one's self talk, what produces emotions and creativity in alternatives for self-defeating behavior. At the completion of the RBT program, could the subject merely repeat back what had been taught or could be grasp the underlying concepts and

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generalize those concepts to working with his specific type of pathology? The subjects who understand the concepts then applied them to their specific problem areas, would benefit more from RBT.

If the client is merely expecting to learn the RBT language (terms, RSA's, REIS, etc.) then little effect on reducing pathology will occur. If the client is expecting to learn the underlying concepts, a more positive outcome will probably be effected.

Psychopathology:

This issue concerns what types of problems are best treated by RBT. It is speculated that individuals with anxiety and/or depression either of a chronic or reactive nature respond better than individuals with in-remission schizophrenia or personality disorders. However, there is some evidence that persons with Histronic Personalities can improve response to crisis if they have mastered RBT.

In summary, it appears the best candidate is of average or better intellectual functioning, is experiencing some problem related to the distress syndrome (anxiety, depression, etc.) and is expecting to learn the underlying concepts in order to use them with his specific problems.

Suggestions for further RBT projects might include the following:

1. Increase N for any research projects.

2. Number of participants in any individual group to be between five and fifteen.

3. Voluntary participants to have a minimum I.Q. of 85.

4. Improved measures of pre and posttesting; e.g. MMPI, Rorschach, facility write-ups, etc., in addition to such measures as the Beck or IBT.

5. Improved monitoring of control groups.

6. Improved control of variables affecting interpretation of results, e.g., demographic date, length of sentence, intellectual functioning, type of psychopathology.

7. Interpretation of, and improved control over, drop-out rates.

8. Monitoring of consistency of delivery of program.

9. Long-term follow up of participants.

10. A preparatory session with each participant to clarify the RBT program.

11. Establishing criteria for successful completion of program to include:

    a. successful completion of RSA's.

    b. application of RSA's to relevant problem areas for the participants.

    c. application of REI's to relevant problem area for the participant.

    d. where possible, in vivo practice of (b) and (c).

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Finally, special commendation is to be given to those trainers cited earlier in this report. Extensive professionalism and effort was demonstrated by all of these individuals who carried out the program. Their participation was very much appreciated.

Mark Englander, Ph.D.

APPENDIX E

State of Pennsylvania Anger Management Program

ABSTRACT

Stress inoculation training has been found to be effective in treating individuals with anger management problems (Novaco, 1977a; Schlichter & Horan, 1981). As conceived by Meichenbaum and his associates (Meichenbaum & Turk, 1976), this intervention has three phases or components including education, coping skills training, and exposure to a stressor. The present study investigated the efficacy of these components within a comprehensive anger management treatment package. Five treatment cells were relevant to this analysis: (1) No treatment control (NT); (2) Education only (Ed); (3) Education plus coping skills (CS); (4) Education plus exposure (Ex); (5) Education plus coping skills plus exposure, i.e., stress inoculation (SI). These treatment conditions were arranged in a basic 2 x 2 + 1 format, namely, the presence or absence of the coping skills and exposure components plus NT, with the cell defined by the absence of these factors occupied by education only. Each active treatment condition was equivalent in terms of credibility and the participants' expectancy for therapeutic change.

Fifty adult male offenders confined in a medium security prison with conduct records suggesting faulty anger control volunteered to participate in the study. All were pretested, stratified according to race, and randomly assigned to one of the five experimental conditions. Within the four active treatment conditions, participants were then randomly assigned to one of two trained therapists. Treatment was conducted over a five-week period with the number of individual therapy sessions (from 2 to 10) determined by the requirements of the

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treatments alone and in combination. At the conclusion of treatment, participants were posttested and three months later they were recontacted for follow-up assessment. There were four dropouts during treatment and two at follow-up.

Posttest analyses for the 2 x 2 part of the design, which included the high demand control condition (Ed), demonstrated significant main effects favoring the coping skills component on both the self-report anger inventory and the behavioral ratings of the role-played provocation scenes (including a generalization subtest). At follow-up, when only the self-report measure was administered, there were no longer any significant differences. There were no differences at posttest or follow-up on the number of aggressive misconduct reports received during those time periods. No main effects for the exposure component or interactions emerged on any posttest or follow-up measure. The additional comparisons between the high demand control condition and NT indicated no differences on any measure on either occasion.

Ex post facto comparisons were utilized to determine whether active treatment conditions which did not prove superior to the high demand control condition (Ed) would be superior to NT on any measure. Results indicated that at posttest Ex, while not better than Ed, was superior to NT on the role-play measure (excluding the generalization scenes) but not on the anger inventory. While none of the active treatment conditions had proved superior to Ed in terms of the follow-up anger inventory, all three active treatment conditions (i.e., CS, Ex and SI) produced less self-reported anger than NT. Similar comparisons with the misconduct data indicated that at posttest the two conditions

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involving coping skills training (CS and SI) did result in fewer aggressive misconducts than NT; however, at follow-up there were no significant differences between any active treatment condition and NT.

This study demonstrated the efficacy of the coping skills component in stress inoculation applied to aggressive public offenders. The exposure component did not add to the efficacy of SI, perhaps because the provocative nature of daily prison living may have provided participants with an informal exposure treatment. The education component had logical if not empirical value for SI because its content provided the cognitive basis for the coping skills and exposure components.

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Anger Management Program at Washington's SOC

Classes of 12 to 14 members are held for two hours per week for a period of eight (8) weeks. All inmates have a pre-treatment interview to determine their specific problems and their suitability for the class. Up to the present time membership is open to the general population and no one has been denied access. Most inmate referrals come from peers. Others are referred by custodial, medical, and counseling staff. The majority of men who join, complete the class. The following is a description of the program:

During the intake interview an extensive discussion of the individual's anger problems, patterns of anger expression, and the personal consequences they have suffered due to dysfunctional expression of anger are explored. In addition, relevant medical, mental health, and drug and/or alcohol information is obtained. A verbal description of the program is given to them and they are given the booklet published by Blue Cross entitled "Stress". They are asked to read the first and last chapters before the class begins.

Treatment: Behavioral self-monitoring
Cognitive restructuring
Relaxation training

Each session begins with a review of homework and a discussion of situations that appeare during the week. The session ends with some form of relaxation. Clients are requested t try out a new behavior or idea and report on it the following week. Appropriate handouts are available for each session.

Session One: Stress is ... The first session begins with a group discussion of ways the individuals are already handling stress in a positive manner such as participation in sports, talking it out, etc. Next, is a discussion of various personal stress problems they are dealing with, particular aspects that trigger their anger, as well as how they respond. An educational talk is then presented on what stress is, the fight or flight response, type A behavior, and the Holmes life change material. After a short break they are then given information on the importance of learning to retrain the central nervous system through the daily use of relaxation and they are put through a 45 minute progressiv muscle relaxation session. In this way they will become more aware of the difference between tension and relaxation in the various muscle groups. This is important in their future self-monitoring of tension levels. Finally, they are asked to keep a log of their anger experiences for seven days and rate them on a one to ten scale. This information is confidential and will be repeatedly used by them in the following weeks.

Session Two: Anger is ... Group discussion is focused on how they have learned or been conditioned to their individual response to anger; male and female socialization patterns; the "macho image", especially in the institutional setting; the use of specific anger responses to manipulate, intimidate, etc.; and the disruptive and defensive roles of anger. Also explored are the negative consequences (to them) of their previous methods of handling anger, and possible alternative ways that would have more positive consequences for them. In addition, the role of internal dialogue in the escalation of anger is discussed.

Session Three: Anger management principles. A group discussion using the anger managemen principles from the book, "Anger Control" by Raymond Novaco, is held. Some of the principles include:

1. Recognizing that anger often has to do with feeling threatened or having low self-esteem.
2. Avoiding ego involvement or personalizing a situation - staying task oriented and determining what needs to be done to get the desired outcome.

3. Becoming aware of dysfunctional habit patterns and learning new behaviors.
4. Becoming increasingly aware of physical tension and using that arousal as a cue to deep breathe, relax, and stay task oriented.
5. Learning to act rather than react by maintaining self-control rather than being caught up in another's problem. This idea is very crucial and I use reframing here. For many inmates it is considered "macho" to respond with violence and aggression. For the individual to change it is imperative that he now consider staying task oriented, walking away, etc. as the "manly" in-control response. If this change in perception does not happen he will be less inclined to change his behavior.
6. Using an analysis of the problem and breaking it down into small manageable parts. This enables the individual to problem solve each specific part. The parts include the following sequence: Situation (trigger) - - memories of past experiences - - self-talk - - emotion or feeling - - physical reaction - - behavior - - consequences - - self-talk. These are parts of a predictable (for that person) habit pattern that take place within a few seconds. We slow down the sequence and find helpful alternative responses for each specific area. Intervention in any of the areas will change the behavior and consequences.
7. Remembering to self-reinforce for positive change and to use mistakes as a learning experience to plan for the next time.

In addition, a list of self-statements for confronting and coping with provocation is handed out.

Session Four: Self-talk is ... This group session includes a discussion of how to analyze self-talk in terms of basic "Rational Emotive Principles" (Ellis 1962), and "Behavioral Self-Control" (Thoreson and Mahoney 1974). Sharing their experiences, in the group setting, with dysfunctional or unhelpful thought patterns help them to realize that the way they talk to themselves directly determines the way they feel and act. Being aware, and then being able to confront, challenge, and change irrational beliefs and assumptions, while developing alternative beliefs and self-statements, greatly reduces anxiety. In addition, it has a direct impact on the very perception of stress or anger. Individuals often report that situations no longer bother them as they used to.

Other important areas of discussion include the pitfalls of internalizing, catastrophizing and maintaining unrealistic expectations of themselves or others.

Session Five: Straight thinking. A discussion of the inner-directed versus outer-directe person is held. Arron Beck and his work on depression (Butler, 1981) lists various areas of erroneous thinking that cause psychological stress. They include:

1. Arbitrary Inferences: Drawing conclusions without carefully considering the facts.
2. Misattribution: The direction of blame or responsibility away from the real cause onto something or someone else.
3. Cognitive Deficiency: Failure to be aware of the full picture (tunnel vision, deni
4. Over-Generalization: To recognize only the similarities between people or between events and to ignore the differences. (Using always, never, everything, and everytime.)
5. Either/Or Thinking: Thinking in extremes.
6. Vague Language: Not being specific.
7. Magnification or Catastrophizing: The process by which we over-estimate the importance of an event or situation.

As we explore these areas, individuals become more aware of how dysfunctional self-talk is usually caused by problems in one of these seven areas of thinking. This work helps them to begin taking increasing responsibility for their own personal choices. It also allows them to make the necessary changes, rather than to remain a victim as they perceive themselves to be when they consider their difficulties to be the result of outside forces.

Session Six: Communication skills - This session involves discussing and role playing various assertive communication skills, especially the giving of negative feedback in a positive way. For example, sending "I" messages, which state feelings and opinions, rather than "you" messages, which attack with negative labels the integrity of another person and produce defensiveness, is encouraged. In addition, identification is made of the various constraints such as the need for peer approval, which make it difficult for some to communicate effectively. Due to lack of assertive skills many individuals bottle up their anger until it becomes explosive and then is followed by aggression. The group also practices active listening as a skill that can be used to help an agitated person to de-escalate.

Session Seven: Planning session - The group begins working out ideas for the handling of specific situational problems of its members. They use a planning sheet to write down options and alternative behaviors.

Session Eight: Review and discussion of strategies - This final session includes a discussion of what the members have learned. They have gained not only new ways of counteracting the anger response, but also new ways of assessing all of their experiences. They are encouraged to continue self-monitoring and to regularly review the material. They are also invited to retake the class or to come in for an individual follow-up appointment if necessary.

The relaxations during all of these sessions include muscle relaxation, self-hypnosis, yoga, and meditation. The yoga and meditation sessions are taught by inmates. Using visual imagery such as selecting a stressful situation, visualizing himself beginning to get tense, and then to imagine himself relaxing, talking to and instructing himself in an appropriate calming manner, rationally re-evaluating his fear, and then proceeding to cope smoothly and calmly with the situation, are added to the relaxation sessions in imaginal rehearsal.

Inmates report that learning relaxation as a response to anger cues, becoming aware of the role of the thinking process in the behavioral sequence, and learning to interrupt maladaptive self-talk with more helpful and appropriate internal dialogue, are the areas that have proven to be the most helpful to them.

As this is a new program and because of the time constraints in this setting, clinical research has not been done. That, and the development of extensive role play for advance classes would provide future challenges in this area.

Enclosed is a bibliography and a strategy sheet which summarizes topics discussed.

March 28, 1982

CONCEPTS, POLICIES AND RESPONSIBILITIES

Based on our first six years' operations, the following concepts, policies and responsibilities have been used and appear sound.

a. Status of Growth Orientation, Inc. Growth Orientation, Inc. is an independent, non-profit organization dedicated exclusively to serving humanity, our society and the individual. Our initial effort has been within the Florida correctional community at Florida State Prison, Union Correctional Institution and Florida Correctional Institution for Women. We foresee operations in other institutions in Florida. We also foresee related operations in the larger communities in the state of Florida, devoted to reducing crime and assisting the offender to become a respected and responsible member of his selected community.

We operate within the institutions as a separate and independent entity. We abide by the rules and regulations of the institution and support Department of Corrections and institutional policies. We have developed over these past years a reputation of integrity, sincerety and genuine concern for the inmate and his problems. We maintain a status among inmates that cannot be achieved by the institution itself, for we are not part of the "establishment", the "institution" or the "bureaucracy", hence we are viewed in a different light. We enjoy a credibility with the inmates that cannot be paralleled by any agency of government. This undoubtedly accounts for much of the success of our efforts. We are placed in the delicate position of using but not abusing our special status. We feel that we have done this well, and will continue to do so. It is imperative that we zealously guard our reputation and integrity.

b. Basic Structure. The basic structure of our operations in the correctional environment involves

training carefully selected inmates to operate various activities within the institution related to our program. A major strength of our program lies in peer influence of fellow inmates applied in a positive and controlled direction, leading to beneficial involvement and self-improvement.

c. Inmate Assumption of Responsibility. From the beginning, our program has placed heavy reliance on the integrity and responsibility of our inmate staffs. The inmates of our staffs have repeatedly demonstrated that this confidence has not been misplaced. A review of the past histories of some of these inmates would reveal the remarkable contrast that has been achieved through our program.

Similarly, we have placed heavy reliance on a sense of integrity and responsibility on the participants of our activities. Here, too, our confidence has been rewarded. Under the laboratory conditions of our workshop, it is clearly evident that we can trust the inmates -- almost without exception. Responsible conduct is expected and they respond well. Worthy of mention is the fact that over 4,000 inmates have participated in our programs during the last six years, with about 400,000 hours of inmate participation in our activities -- without the slightest adverse incident of any type. In our environment, the inmates remain essentially trouble free, responsible citizens. Correctional officers are not required nor normally present at our activities to maintain dsicipline or control. These items are more remarkable because we have by now taken through our programs the roughest and toughest that the state of Florida has to offer.

d. Training the Inmate Staff. Training carefully selected inmates for our staff is a delicate and lengthy process. Careful screening is imperative. Effectiveness of the program depends heavily upon the caliber, abilities and attitudes of these crucial inmates. They must be held in high regard by both the institution and the inmate population. Once in the program, no deviation from honesty and integrity can be tolerated. In six years of operations in three institutions we have had no blemish on our record of performance.

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e. Institutional Coordinator. Our activities within the institution are supervised by an Institutional Coordinator. As the name implies, he is responsible for the effective operation of all our program's elements within his institution. He is responsible to the superintendent for complying with all appropriate rules and regulations and, in general, for supporting the requirements and objectives of the institutions. His job is to operate our activities effectively with the minimum of confusion or disruption of institutional routine.

He is, at the same time, responsible to Growth Orientation, Inc. for all matters related to our comprehensive Growth Program itself. This includes the selection, training and general supervision of assigned inmates. Good leadership is a key to our program effectiveness and is therefore a basic requirement for this important position. Comprehensive and frequent communications between our State Program Director and the Institutional Coordinator are both fundamental and vital.

f. Operation of Program Elements. The actual Integrated Growth Program content and its operation are the exclusive property and responsibility of Growth Orientation, Inc. Thus, on matters related to the program and its content, and to its day-to-day operation, the Institutional Coordinator is directly responsible to the corporation through its designated State Program Director. The Institutional Coordinator is critical to out operations and the person occupying this position must have the respect and confidence of the Department of Corrections, the institution, the inmates and the corporation. A high degree of coordination is required between the institution and the corporation in selecting this critical person.

g. Operating Procedures. The Corporate President and our State Program Director work directly with the Secretary and other members of the Department of Correction's central office staff in developing policies and operating procedures that apply to all institutions in which we operate. Our State Program Director works directly with each Superintendent on matters relating to policy and overall coordination of the program in that institution. The Institutional Coordinator works directly with his Assistant Superintendent on the routine coordination of the various elements of our program.

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Specific procedures for coordination and operation of our program will vary with each institution. Accordingly, it is appropriate that the Institutional Coordinator and his Assistant Superintendent jointly develop a specific set of procedures for operation of each element of our program at that institution. Prior to becoming effective, these operating procedures will then be jointly reviewed and approved by the Superintendent and State Program Director.

h. Communications. Effective communications are the most critical element of any organization. They make or break the organization. Failure to communicate effectively can cause confusion and become a major morale problem. There is much initiative demonstrated by people in our organization, and this is as it should be. It is constructive and healthy. However, failure of communications often causes enthusiastic people to work on divergent objectives. The strength of the team is thus dissipated and in the end enthusiasm is dampened.-- team effectiveness suffers. It is therefore imperative that the State Program Director be kept continually abreast of even the smallest details, on a weekly basis -- daily or hourly, if appropriate.

Periodic reports of activities and events to the State Program Director and the President serve as an aid in carrying out this function. The State Program Director will coordinate with the Institutional Coordinator in developing appropriate reporting procedures. Copies of certain reports may be provided to the Superintendent and the Department.

i. Correspondence. All communications and communications with persons or organizations outside the institution concerning GOLAB and its operation invariably involve policy, commitment, procedures, understandings, future planning, or at the minimum, the reputation of GOLAB and of Growth Orientation, Inc. For this reason, all communications involving any aspect of GOLAB with persons or organizations outside the institution must be carefully controlled. This is the responsibility of the State Program Director. All such communications must be approved by the State Program Director prior to transmission.

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h. GOLAB Visits. All scheduled visits to the GOLAB are important and must be coordinated with the State Program Director. These requirements are fundamental to our operations. Specific procedures will be developed between the State Program Director and each Institutional Coordinator.

The preceding is not intended to limit or restrict tours or casual visits conducted by the Institution from visiting GOLAB. To the contrary, such visits are encouraged for they are beneficial to all concerned. Brief advance notice is helpful so that the GOLAB schedule can be adjusted to avoid embarassment during certain sensitive phases of GOLAB.

M. V. Stack

Martin V. Stack
President, Growth Orientation, Inc.

Delia M. Anderson

Delia M. Anderson
Florida State Program Director

Marcellas Durham

Marcellas Durham
Assistant Secretary for Programs
Florida Department of Corrections